Male Family Planning / STD Visit

Please answer all questions below: ***(Do not urinate before exam!)***

Last Name	First	Age	Who do you live with
Home Phone Number	**Message / Pager Number**		**Best Time to Call**

What is the main reason for your visit today? _____

Are you allergic to any medicines? ☐ Yes ☐ No

Which ones and describe what happened: _____

Do you take medicines, natural remedies, aspirin, or other drugs every day? ☐ Yes ☐ No

List them: _____

Are you up to date with your immunizations, like Rubella and Hepatitis B? ☐ Yes ☐ No ☐ Unknown

Do you use tobacco? ☐ Yes ☐ No How much do you use? _____ How many years? _____

Do you drink alcohol? ☐ Yes ☐ No How often? ☐ Daily ☐ Weekly ☐ Monthly

How many alcoholic drinks do you have? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5+ drinks

Do you use other drugs (examples: marijuana, cocaine or IV drugs)? ☐ Yes ☐ No

What do you use? _____ How often? ☐ Daily ☐ Weekly ☐ Monthly

Have you ever had or do you have: High blood pressure .... ☐ Yes ☐ No Hepatitis (turned yellow) ..... ☐ Yes ☐ No
IV drug use ..... ☐ Yes ☐ No Problems with your kidneys or bladder ... ☐ Yes ☐ No
Any other serious medical condition… ☐ Yes ☐ No

Have you ever had a sexually transmitted disease or genital infection? ☐ Yes ☐ No

(check the ones you think you might have had) ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts
☐ Syphilis ☐ HIV ☐ Jock Itch ☐ Hepatitis B or C

Our services are confidential, however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

How many different sex partners have you had in the last 12 months? _____

Were your partners (check): ☐ women ☐ men ☐ both ☐ IV drug user ☐ bisexual ☐ a partner with multiple sex partners or at risk for HIV or STD

How long have you been with your current sex partner(s)? _____

What type of sex have you had in the past 2 months (check): ☐ Vaginal ☐ Oral ☐ Anal ☐ Other ☐ No sex

Are you and your current sex partner(s) using a birth control method (if any of your sex partners are female)?

If so, what kind? _____

Do you have symptoms of a genital infection? ☐ Yes ☐ No (check the ones you have)

☐ Rash ☐ Itch / Pain ☐ Pain with urination ☐ Urgent or frequent urination ☐ Stool or anal problems
☐ Bumps ☐ Burning ☐ Sores ☐ Drip / Discharge ☐ Rectal bleeding

Have you had sexual contact with a person with a positive STD test? ☐ No ☐ Yes

Have you had a positive STD test in the last year? ☐ No ☐ Yes

Date of your last sexual contact? _____ **Did you use a condom**? ☐ Yes ☐ No

Have you used condoms before? ☐ Yes ☐ No

How many hours since you last urinated? _____

Reviewed by _____ Date: _____

Housing Status: _____

CC: _____

ROS: ☐ Constitutional ☐ Skin ☐ GI ☐ GU ☐ Breast ☐ Neuro ☐ CV ☐ Resp ☐ Ent ☐ Eyes ☐ Musculoskeletal

PMH / SH / FH: (negative if checked, unless specified)

HPI:

☐ HIV testing requested for client.....☐ Client agrees
☐ HIV testing recommended for client .....☐ Client agrees

BP_____ WT_____ HT_____

	NL	ABNL	N/A
Skin	☐	☐	☐
Lungs	☐	☐	☐
Heart	☐	☐	☐
Abdomen	☐	☐	☐
Groin lymph nodes	☐	☐	☐
Urethral discharge	☐	☐	☐
Penis shaft	☐	☐	☐
Penis glands	☐	☐	☐
Scrotum	☐	☐	☐
Inguinal canal	☐	☐	☐
Testes descended	☐	☐	☐
Rectal exam	☐	☐	☐
Anal area	☐	☐	☐

Stat Tests Done:

☐ UA dip: LE _____ Nitrate _____
Prot _____ Blood _____
Other _____

Education: ☐ ECRR ☐ Testicular self exam
Smoking: ☐ advised to quit/congratulated ☐ Hep B
☐ Partner treatment ☐ Partner's contraceptive method
☐ Condom use ☐ Contraception ☐ STD HIV Prevention
☐ Abstinence ☐ ECP ☐ Other

Literature Given: ☐ Smoking ☐ HIV ☐ STD's ☐ Condoms
Other: _____

Assessment:

Tests Sent: ☐ CT ☐ GC ☐ HSV ☐ HIV ☐ RPR ☐ Hep B ☐ Hep C

Plan:

Check medications prescribed:

1. ☐ Condoms: _____ # given
2. ☐ Azithromycin ..... 1 gm PO
3. ☐ Ceftriaxone ..... 125 mg 1M given
4. ☐ Cefpodoxime..... 200 mg #2 PO
5. ☐ Doxycycline..... 100 mg 1 PO BID x 7 days
6. ☐ Metronidazole .... 500 mg 4 PO once
7. ☐ Acyclovir ..... 400 mg 1 PO TID x _____ days
8. ☐ Hep B vaccine injection site _____ lot #
9. ☐ Other:

Signature _____ Date _____